Meeting Minutes

Joint Commission on Health Care

Tuesday, September 18, 2018 – 9:00 a.m.
Senate Committee Room A- Pocahontas Building

Members Present

Delegate Benjamin L. Cline
Delegate T. Scott Garrett, Vice Chair
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Senator George L. Barker
Senator Rosalyn R. Dance, Chair
Senator Siobhan S. Dunnavant
Senator John S. Edwards
Senator Glenn H. Sturtevant, Jr. (call in)
Senator David R. Suetterlein

Secretary Daniel Carey, MD

Members Absent

Delegate David L Bulova
Delegate C.E Cliff Hayes, Jr.
Delegate Kaye Kory
Delegate Roslyn C. Tyler
Senator Charles W. Carrico, Sr.
Senator L. Louise Lucas

Staff Present

Michele Chesser
Paula Margolis
Andrew Mitchell
Stephen Weiss
Agnes Dymora

Call to Order

Delegate Garrett called the meeting to order

Governor Northam's Health and Human Resources (HHR) Strategic Priorities

Secretary of HHR Daniel Carey, M.D. presented background information on the goals of the *triple aim* which include: better care for individuals, better care for the population, and lower cost through quality improvement; and he remarked on how achieving these goals will strengthen the economy, maximize the impact of tax dollars and give everyone a chance for living a healthy, safe and successful life. Dr. Cary then reviewed Governor Northam's strategic priorities which include: 1) Medicaid expansion; 2) initiatives for improving access to behavioral health, substance use disorder (SUD), and developmental services; 3) improving women's health services; and, 4) improving children's health and education services.

Update on Medicaid Addiction and Recovery Treatment Services Program (ARTS)

The Department of Medical Assistance Services (DMAS) Deputy Director of Complex Care, Ms. Tammy Whitlock, provided an update of the legislative changes to the ARTS program approved in the 2016 General Assembly session. Changes included expanding Substance Abuse Disorder (SUD) services to include inpatient detoxification, short-term

residential treatment, peer support services, and provider training and recruitment activities. Ms. Whitlock then discussed the inclusion of all ARTS services in the managed care programs and the added services and federal funding resources provided through the Medicaid Section 1115 Demonstration Waiver which was approved by the Centers for Medicare and Medicaid Services (CMS) in 2016. The Waiver allows Virginia to receive federal matching funds for services provided by SUD residential treatment facilities.

Katherine Neuhausen, M.D., M.P.H, DMAS Chief Medical Officer, discussed the independent evaluation of the Section 1115 Wavier Demonstration performed by Virginia Commonwealth University. DMAS efforts have resulted in an increase of over 440 new addiction treatment provider sites that serve ARTS enrollees. In addition, the number of ARTS members receiving SUD treatment increased by 57 percent, and the number of ARTS members with opioid use disorder receiving treatment increased by 48 percent. The evaluation also revealed that emergency department (ED) visits related to SUD decreased by 14%, opioid related ED visits decreased by 25%, inpatient admissions for SUD decreased 4%, and opioid related inpatient admissions decreased by 6% in the first 10 months of the program. Dr. Neuhausen also reported that the number of prescriptions for opioid pain medications decreased by 27% and the number of ARTS enrollees who received opioid prescriptions decreased by 17 percent. The ARTS program resulted in an increase in the number of enrollees with access to Medication Assisted Treatment (MAT) for maintaining abstinence with a 75% reduction of overdose deaths in the population receiving MAT, compared to those not receiving MAT. Lastly, it was noted that DMAS collaborated with several other agencies within the HHR secretariat in order to achieve the goals of the ARTS program.

Staff Report: Quality of Health Care in Virginia Jails and Prisons

JCHC Senior Health Policy Analyst, Mr. Stephen Weiss, presented the final report of a two-year study of the quality of health care services in Virginia jails and prisons, including whether or not the Community Services Boards (CSBs) should be required to provide mental health services in jails and the impact of such a requirement. The study was approved during the JCHC work plan meeting in May, 2017, based on resolutions by Delegate O'Bannon (HJR 616) and Delegate Holcomb (HJR 779).

The Virginia Department of Corrections (VADOC) is legally required to provide health care to individuals who are incarcerated. Challenges to providing health care include aging of the population of offenders and a shortage of health care providers willing to serve the population. Strategies used to address these challenged have included contracting with outside vendors, the use of temporary staff, and moving offenders to different jail and prison locations which have the capacity to address specific needs, such as geriatric and dementia care, behavioral health needs, and treatment for pregnant opioid-addicted women. One challenge is that none of the facilities health care records systems are integrated, and health care records must be transferred to facilities and conveyed to providers either physically or by facsimile, which is very inefficient, particularly when involving offenders with voluminous medical records. The VADOC health records system needs to be updated and upgraded to allow health care information to be updated and shared in an efficient manner.

According to the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the percent of the jail population suspected of having *any* mental illness was 17.63% in 2017 and the percent suspected of have having a *serious* mental illness was 9.55 percent. Sixty percent of the mental health treatment provided in Virginia jails is performed by CSBs. In addition, six jail-based mental health pilot projects were funded for two years (State Fiscal Years 2017 and 2018) in order to attempt to overcome challenges such as the lack of staff continuity and data. One challenge encountered is confusion over Health Information Portability and Accountability Act (HIPAA) requirements involving offenders. The report recommends that the state develop a single HIPAA-compliant form to be used by all localities for all offenders and that an interagency, intergovernmental best practices committee be formed to overcome barriers and improve the delivery of services in local and regional jails.

Staff Report: Virginia Drug Disposal Program

JCHC Senior Health Policy Analyst, Dr. Andrew Mitchell, presented the study which was requested by the Senate Education and Health Committee. Dr. Mitchell conveyed that per a 2017 study published in the Journal of the American Medical Association, two-thirds of opioid medications prescribed after a surgery were not consumed and that there is the potential for health and environmental risks of inappropriate medicine disposal (such as pouring medicine down a sink or flushing down a commode).

Federal regulations allow for the public to deliver unused controlled substances to a law enforcement agency and authorized retail pharmacies as collectors of unused drugs. There is also a mail back program authorized by the Drug Enforcement Administration (DEA). Medicine take-back models used by other States and municipalities were described, including those regulated, funded and/or implemented by governments highlighting Washington State's Unwanted Medication Disposal Act, which adopts an *Extended Producer Responsibility* approach.

Current access to and use of recommended disposal methods are under-utilized. At the time of the presentation, approximately 4% of Virginia pharmacies were registered as authorized collectors and less than half of Virginia residents live within five miles of a disposal bin used in the DEA program. Pharmacies report that cost is a barrier to participating in a disposal program. Five policy options were provided that included establishing a statewide medicine collection and disposal program as well as increasing consumer awareness of appropriate disposal methods.

Staff Report: Medical Aid in Dying

Delegate Kaye Kory requested via letter that the JCHC study the issue of Medical Aid-in-Dying (MAID) including a review of states that currently authorize the process. Dr. Chesser, Executive Director of the JCHC, conducted the two-year study and provided the final presentation. MAID is the ability of a patient to obtain, from a physician, a medication that the patient may use to end their life if they are competent, terminally ill, and over 18 years of age. Oregon (1998), Washington (2008), Vermont (2013), California (2016), Colorado (2016), Washington, D.C. (2017), Hawaii (2018) and Montana (by judicial review in 2009) are the states that allow MAID. Currently, Virginia Statute § 8.01-622.1 provides an injunction against assisted suicide, allows for the recovery of compensatory and punitive damages, and indicates that a health care provider who assists/attempts to assist a suicide shall have his/her certificate or

license to provide health care services in the Commonwealth suspended or revoked by the licensing authority. If legalized, Code would need to be changed to exempt MAID from provisions in this statute.

Dr. Chesser provided information about a work group of stakeholders created to discuss the issue, including areas of work group member disagreement, and addressed questions asked by Delegate Kory in her study request. Also, key elements of the POLST (Physician Orders for life Sustaining Treatment) program were presented as a means to improve end of life care in Virginia. Dr. Chesser concluded the presentation by discussing the policy options regarding MAID and POLST.

Adjourn

Electronic Meeting: YES
Senator Sturtevant had a schedule conflict.
Prepared by: Paula Margolis